TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Dallas County Hospital

Respondent Name
General Casualty Co of Wisconsin

MFDR Tracking Number
M4-16-2938-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
May 23, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The Requestor appealed the Carrier's determination in the Request for Reconsideration on date. Applicable mailing records indicate that it was received by Sedgwick CMS on the date of 10/19/2015."

Amount in Dispute: $509.67

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Subject to further review, the carrier asserts that it has paid according to applicable fee guidelines and challenges whether the disputed charges are consistent with applicable fee guidelines."

Response submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 17, 2015	Outpatient hospital services	$509.67	$489.10

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for outpatient hospital services.
3. 28 Texas Administrative Code §133.20 sets out the requirements for medical claim submission.

4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
    - 29 – the time limit for filing has expired
    - W3 – Additional payment made on appeal/reconsideration
    - 193 – Original payment decision is being maintained

Issues

1. Is there evidence of timely filing?
2. What is the Medicare payment rule?
3. What is the applicable Division Rule that pertains to reimbursement?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The carrier denied the services in dispute with adjustment reason code 29 – "The time limit for filing has expired." 28 Texas Administrative Code §133.20(b) states in pertinent part,

    > Except as provided in Labor Code §408.0272(b), (c) or (d), a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided.

    Review of the submitted documentation finds:

    - USPS tracking sheet that indicates an initial mailed date of October 12, 2015
    - Delivery date of October 19, 2015 to Sun Prairie, WI

    This delivery date is within 95 day time limit. The carrier's denial is not supported therefore the services in dispute will be reviewed per applicable rules and fee guidelines.

2. The services in dispute are for Outpatient Hospital Services with dates of service July 17, 2015. 28 Texas Administrative Code 134.403 (f) states in pertinent part,

    > The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register.

    The Medicare facility specific reimbursement amount is explained at, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/HospitalOutpaysysfctsht.pdf as:

    > *"The payment rates for most separately payable medical and surgical services are determined by multiplying the prospectively established scaled relative weight for the service's clinical APC by a conversion factor (CF) to arrive at a national unadjusted payment rate for the APC. The scaled relative weight for an APC measures the resource requirements of the service and is based on the geometric mean cost of services in that APC. The CF translates the scaled relative weights into dollar payment rates.*
    >
    > *To account for geographic differences in input prices, the labor portion of the national unadjusted payment rate (60 percent)* ***is further adjusted by the hospital wage index*** *for the area where payment is being made. The remaining 40 percent is not adjusted. You may also receive the following payments in addition to standard OPPS payments:"*

    The facility specific reimbursement amount is calculated as follows:

    Payment rate found at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html

Procedure Code	APC	Status Indicator	Payment Rate	60% labor related	2015 Wage Index Adjustment for	40% non-labor related	Payment

					provider		
12002	0012	Q1	N/A				
99283	0614	V	$198.39	$119.03 X 60% = $119.03	0.9512 X $119.03 = $113.22	$79.36 + $113.22 = $	$113.22 + $79.36 = $192.58
90714		N	N/A				
90471	0437	S	$53.54	$53.54 X 60% = $32.12	0.9512 X $32.12 = $30.55	$53.54 X 40% = $21.42	$30.55 + $21.42 = $51.97

The Medicare Claims processing Manual defines the terms, Status Indicators, APC Payment Groups and Composite APCS as follows:

10.2 - APC Payment Groups

Each HCPCS code for which separate payment is made under the OPPS is assigned to an ambulatory payment classification (APC) group. The payment rate and coinsurance amount calculated for an APC apply to all of the services assigned to the APC. A hospital may receive a number of APC payments for the services furnished to a patient on a single day; however, multiple surgical procedures furnished on the same day are subject to discounting. (See section 10.5 for discussion of multiple procedure discounting under the OPPS).

10.1.1 - Payment Status Indicators

An OPPS payment status indicator is assigned to every HCPCS code. The status indicator identifies whether the service described by the HCPCS code is paid under the OPPS and if so, whether payment is made separately or packaged. The status indicator may also provide additional information about how the code is paid under the OPPS or under another payment system or fee schedule. For example, services with status indicator A are paid under a fee schedule or payment system other than the OPPS. Services with status indicator N are paid under the OPPS, but their payment is packaged into payment for a separately paid service. Services with status indicator T are paid separately under OPPS but a multiple procedure payment reduction applies when two or more services with a status indicator of T are billed on the same date of service.

The full list of status indicators and their definitions is published in Addendum D1 of the OPPS/ASC proposed and final rules each year. The status indicator for each HCPCS code is shown in OPPS Addendum B.

Review of the submitted medical claim finds the following:

- Procedure code 12002 has status indicator Q1 denoting STVX-packaged codes; payment for these services is packaged into the payment for any other procedures with status indicators S, T, V, or X performed on the same date. This code may be separately payable only if no other such procedures are reported for the same date.
- Procedure code 90714 has status indicator N denoting packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.

3. 28 Texas Administrative Code 134.403 (f) states in pertinent part,

The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.

(1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:

(A) 200 percent; unless

(B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent.

Review of the submitted medical claim finds implants were not requested. The maximum allowable reimbursement for the services in dispute listed on DWC 60 is calculated as follows:

- Procedure code 99283 has status indicator V denoting a clinic or emergency department visit paid under OPPS with separate APC payment. The total Medicare facility specific reimbursement amount for this line is $192.58. This amount multiplied by 200% yields a MAR of $385.16.
- Procedure code 90471 has status indicator S denoting a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. The total Medicare facility specific reimbursement amount for this line is $51.97. This amount multiplied by 200% yields a MAR of $103.94.

4. The total allowable reimbursement for the services in dispute is $489.10. This amount less the amount previously paid by the insurance carrier of $0.00 leaves an amount due to the requestor of $489.10. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $489.10.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $489.10 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		June , 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.